

AUG 16 1940
Registration District No. 461

Primary Registration District No. 3024.

Registrar's No.

1. PLACE OF DEATH:
(a) County Lafayette
(b) City or town Lexington
(c) Name of hospital or institution: S. 23 St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 50 yrs. (Specify whether years, months or days)

3. (a) PRINT FULL NAME: James Thomas Martin
3. (b) If veteran, name war -
3. (c) Social Security No. -

4. Sex Ma 5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Eusee K. Hurst 6. (c) Age of husband or wife if alive 75 years
7. Birth date of deceased Feb. 9 1858
(Month) (Day) (Year)

8. AGE: Years 82 Months 5 Days 19
If less than one day hr. min.

9. Birthplace Penn.
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business Coal Miner

12. Name Not known
13. Birthplace "
(City, town, or county) (State or foreign country)
14. Maiden name Not known
15. Birthplace "
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Clyde Martin

(b) Address Lexington, Mo

17. (a) Burial (b) Date thereof July 30-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lexington, Mo

18. (a) Signature of funeral director Wingfield

(b) Address Lexington, Mo

19. (a) Aug 7-40 (b) Helena Bates
(Date registered local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Lafayette
(c) City or town city
(If outside city or town limits, write "RURAL")
(d) Street No. S. 23rd St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 28
year 1940 hour 110 minute 30 P. M.

21. I hereby certify that I attended the deceased from May, 1935 to July 28, 1940
that I last saw him alive on July 15, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Senility
Arteriosclerosis

Due to Chronic myocarditis
Due to _____

Other conditions none
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) no
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? no

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature B. H. B. Washburn (M. D. or other) M. D.
Address Lexington, Mo Date signed 8/7/40

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Booker

RECEIVED
District Health Officer No. 8
District File Number
Date Filed 8-13-40

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *Garret J. Mumpel*

Licensed Embalmer No. *3275-*

P. O. Address *Livingston, Me*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.